Small Business Health Options Program (SHOP)

Insurance Application for Employers

kynect, Kentucky's Healthcare Connection, offers a new way for small employers to offer health insurance to their employees through the SHOP. The SHOP is open to all small business owners with 50 or fewer employees.

THINGS TO KNOW

Apply faster online	You can apply faster online at **www.kynect.ky.gov**. If you are working with an insurance agent or kynector to complete this application, the insurance agent or kynector information will need to be reported using **Appendix B**.
Compare plans online	Visit www.kynect.ky.gov to compare the health insurance plans that you can offer to your employees.
To get help	• **Contact an insurance agent or kynector:** Visit our website or call 1-855-4kynect (459-6328) for a list of insurance agents and kynectors near you. • **Online**: **www.kynect.ky.gov** • **By phone:** Call Customer Service at **1-855-4kynect (459-6328)** • **En Español:** Llame a nuestro Servicio al Cliente gratis al **1-855-4kynect (459-6328)**
What happens next?	• Mail or fax your completed, signed application to: **Office of the Kentucky Health Benefit Exchange** **P.O. Box 4090** **Frankfort, KY 40604** **Fax: 1-502-573-2005** • **Submit the following with your application:** ▪ **The most recent copy of your Quarterly Unemployment Wage and Tax Report (UI-3), if applicable; and** ▪ **Verification of your Federal Employer Identification Number (FEIN)** • You will hear from us when we receive your application. • We will send you detailed information about the steps you will need to follow to select the plan(s) you will offer to your employees and their dependents, if applicable. You will need to go online, call us, or get assistance from an insurance agent or kynector to make your plan selections.

Your information is private.

- We'll keep your information private as required by law.
- We'll use the information on this form only to see if you qualify to participate in the SHOP through kynect and to gather information about the employees to whom you are offering health insurance coverage.

kynect
Kentucky's Healthcare Connection

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STEP 1 Are you eligible to participate in SHOP?

1. Are you a small employer (50 or fewer employees)?	☐ Yes ☐ No
2. Will you offer, at a minimum, all full-time employees (working an average of 30 hours or more per week) coverage in a health insurance plan through the SHOP?	☐ Yes ☐ No
3. If your principal business address is in Kentucky, will you offer coverage to all full-time employees? *OR* If you have a worksite in Kentucky, will you offer coverage to all full- time employees at this worksite?	☐ Yes ☐ No

If you answered **No** to any of these questions, you do not qualify to participate in the SHOP.
If you answered **Yes** to all of these questions, continue to Step 2.

STEP 2 Employer and Contact Information

1. Company Name		2. Federal Employer Identification Number (FEIN)	
3. Doing Business As (DBA)		4. Year of Incorporation/Establishment	
5. Employer Type ☐ Church/church-affiliated ☐ Foreign government ☐ State/local government ☐ Private sector		6. If you marked private sector, check one of the following: ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ 1040 Schedule C Business ☐ Tax-exempt organization	
7. Primary Business Address			
8. City	9. State	10. Zip Code	11. County

Employer Primary Contact

12. First name, Middle initial, Last name & Suffix		13. Title	
14. Mailing Address ☐ **Check here if same as primary business address**			
15. City	16. State	17. Zip Code	18. County
19. Preferred Phone Number ☐Home ☐Work ☐Cell ( )		20. Secondary Phone Number ☐Home ☐Work ☐Cell ( )	
21. Fax Number ( )		22. Email Address	
23. Preferred Spoken Language (if not English)		24. Preferred Written Language (if not English)	

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STEP 3 Employees to Whom You Are Offering Coverage

Attach separate sheets to add more employees or employee dependents.

1

1. Employee Name (First name, Middle initial, Last name)	2. Social Security Number	3. Gender ☐Male ☐Female
4. Date of Birth (mm/dd/yyyy)	5. Email Address (**OPTIONAL**)	6. Phone Number ( )
7. Employee Type ☐ Full time ☐ Contract ☐ Part time	8. Hire Date (mm/dd/yyyy)	9. Annual Salary **(OPTIONAL)**
10. Used tobacco at least 4 times a week in the past 6 months? (defaults to Yes if left blank) ☐Yes ☐No		
11. Home Address	12. City	13. State / 14. Zip Code / 15. County

Enter details of the employee's dependents that will be offered coverage. (OPTIONAL)

16. Dependent Name	17. Date of Birth	18. Gender ☐Male ☐Female	19. Relationship to Employee

2

1. Employee Name (First name, Middle initial, Last name)	2. Social Security Number	3. Gender ☐Male ☐Female
4. Date of Birth (mm/dd/yyyy)	5. Email Address (**OPTIONAL**)	6. Phone Number ( )
7. Employee Type ☐ Full time ☐ Contract ☐ Part time	8. Hire Date (mm/dd/yyyy)	9. Annual Salary **(OPTIONAL)**
10. Used tobacco at least 4 times a week in the past 6 months? (defaults to Yes if left blank) ☐ Yes ☐No		
11. Home Address	12. City	13. State / 14. Zip Code / 15. County

Enter details of the employee's dependents that will be offered coverage. (OPTIONAL)

16. Dependent Name	17. Date of Birth	18. Gender ☐Male ☐Female	19. Relationship to Employee

3

1. Employee Name (First name, Middle initial, Last name)	2. Social Security Number	3. Gender ☐Male ☐Female
4. Date of Birth (mm/dd/yyyy)	5. Email Address(**OPTIONAL**)	6. Phone Number ( )
7. Employee Type ☐ Full time ☐ Contract ☐ Part time	8. Hire Date (mm/dd/yyyy)	9. Annual Salary **(OPTIONAL)**
10. Used tobacco at least 4 times a week in the past 6 months? (defaults to Yes if left blank) ☐Yes ☐No		
11. Home Address	12. City	13. State / 14. Zip Code / 15. County

Enter details of the employee's dependents that will be offered coverage. (OPTIONAL)

16. Dependent Name	17. Date of Birth	18. Gender ☐Male ☐Female	19. Relationship to Employee

4

1. Employee Name (First name, Middle initial, Last name)	2. Social Security Number	3. Gender ☐Male ☐Female
4. Date of Birth (mm/dd/yyyy)	5. Email Address (**OPTIONAL**)	6. Phone Number ( )
7. Employee Type ☐ Full time ☐ Contract ☐ Part time	8. Hire Date (mm/dd/yyyy)	9. Annual Salary **(OPTIONAL)**
10. Used tobacco at least 4 times a week in the past 6 months? (defaults to Yes if left blank) ☐Yes ☐No		
11. Home Address	12. City	13. State / 14. Zip Code / 15. County

Enter details of the employee's dependents that will be offered coverage. (OPTIONAL)

16. Dependent Name	17. Date of Birth	18. Gender ☐Male ☐Female	19. Relationship to Employee

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5	1. Employee Name (First name, Middle initial, Last name)	2. Social Security Number	3. Gender ☐ Male ☐ Female

4. Date of Birth (mm/dd/yyyy)	5. Email Address (**OPTIONAL**)	6. Phone Number ( )

7. Employee Type ☐ Full time ☐ Contract ☐ Part time	8. Hire Date (mm/dd/yyyy)	9. Annual Salary **(OPTIONAL)**	10. Used tobacco at least 4 times a week in the past 6 months? (defaults to Yes if left blank) ☐Yes ☐No

11. Home Address	12. City	13. State	14. Zip Code	15. County

Enter details of the employee's dependents that will be offered coverage. (OPTIONAL)

16. Dependent Name	17. Date of Birth	18. Gender ☐Male ☐Female	19. Relationship to Employee

6	1. Employee Name (First name, Middle initial, Last name)	2. Social Security Number	3. Gender ☐ Male ☐ Female

4. Date of Birth (mm/dd/yyyy)	5. Email Address (**OPTIONAL**)	6. Phone Number ( )

7. Employee Type ☐ Full time ☐ Contract ☐ Part time	8. Hire Date (mm/dd/yyyy)	9. Annual Salary **(OPTIONAL)**	10. Used tobacco at least 4 times a week in the past 6 months? (defaults to Yes if left blank) ☐Yes ☐No

11. Home Address	12. City	13. State	14. Zip Code	15. County

Enter details of the employee's dependents that will be offered coverage. (OPTIONAL)

16. Dependent Name	17. Date of Birth	18. Gender ☐Male ☐Female	19. Relationship to Employee

STEP 4 Sign and Date this Application

- I am signing this application under penalty of perjury which means I have given true answers to all the questions on this form to the best of my knowledge and belief. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell kynect if anything changes from what I wrote on this application within 30 days of the change. I can visit **kynect.ky.gov** or call **1-855-4kynect (459-6328)** to report any changes.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- **My right to appeal.** If I think kynect has made a mistake, I can appeal its decision. To appeal means to tell someone at kynect that I think the action is wrong, and ask for a fair review of the action.

Signature	Date (mm/dd/yyyy)

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